

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Meadows Mennonite Home

0011544 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,052	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,528	3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,194	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	3,355	4,308		7,663	8
9	SNF/PED					9
10	ICF	13,131	17,594		30,725	10
11	ICF/DD					11
12	SC		790		790	12
13	DD 16 OR LESS					13
14	TOTALS	16,486	22,692		39,178	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.32%

D. How many bed-hold days during this year were paid by Public Aid?

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 1958

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date 1958

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	258,674	16,958	19,409	295,041		295,041		295,041			1
2	Food Purchase		262,118		262,118		262,118	(1,217)	260,901			2
3	Housekeeping	192,530	21,383		213,913		213,913		213,913			3
4	Laundry	52,830	12,147		64,977		64,977		64,977			4
5	Heat and Other Utilities			227,129	227,129		227,129	(38,746)	188,383			5
6	Maintenance	149,993	18,423	139,830	308,246		308,246	(98,490)	209,756			6
7	Other (specify):*											7
8	TOTAL General Services	654,027	331,029	386,368	1,371,424		1,371,424	(138,453)	1,232,971			8
	B. Health Care and Programs											
9	Medical Director			4,950	4,950		4,950		4,950			9
10	Nursing and Medical Records	1,792,366	75,980	107,137	1,975,483	(1,547)	1,973,936		1,973,936			10
10a	Therapy	27,582	92	5,305	32,979		32,979		32,979			10a
11	Activities	74,235	3,072	1,079	78,386		78,386		78,386			11
12	Social Services	57,294	69		57,363		57,363		57,363			12
13	Nurse Aide Training					1,547	1,547		1,547			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,951,477	79,213	118,471	2,149,161		2,149,161		2,149,161			16
	C. General Administration											
17	Administrative	73,724			73,724		73,724		73,724			17
18	Directors Fees											18
19	Professional Services			25,667	25,667		25,667		25,667			19
20	Dues, Fees, Subscriptions & Promotions			16,837	16,837	54	16,891		16,891			20
21	Clerical & General Office Expenses	90,723	11,930	155,913	258,566	(4,672)	253,894	(20,928)	232,966			21
22	Employee Benefits & Payroll Taxes			526,131	526,131		526,131	(12,066)	514,065			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,525	4,525	(146)	4,379		4,379			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			134,658	134,658		134,658	(11,717)	122,941			26
27	Other (specify):*											27
28	TOTAL General Administration	164,447	11,930	863,731	1,040,108	(4,764)	1,035,344	(44,711)	990,633			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,769,951	422,172	1,368,570	4,560,693	(4,764)	4,555,929	(183,164)	4,372,765			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Meadows Mennonite Home

#0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			507,704	507,704		507,704	(60,938)	446,766			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			288,010	288,010		288,010	(14,614)	273,396			32
33	Real Estate Taxes			46,233	46,233		46,233	(46,233)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			841,947	841,947		841,947	(121,785)	720,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,370	71,370		71,370		71,370			42
43	Other (specify):*	36,421	4,776	9,152	50,349	4,764	55,113	(55,113)				43
44	TOTAL Special Cost Centers	36,421	4,776	80,522	121,719	4,764	126,483	(55,113)	71,370			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,806,372	426,948	2,291,039	5,524,359		5,524,359	(360,062)	5,164,297			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Meadows Mennonite Home

0011544

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(1,217)	2.2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(12,886)	30.3		9
10 Interest and Other Investment Income	(14,614)	32.3		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties		19.3		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(13,916)	43.3		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising		20.3		28
29 Other-Attach Schedule	(317,429)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (360,062)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (360,062)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39		x			39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule Fundraising	x		4,764	21.3	45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$ 4,764		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Meadows Mennonite Retirement Home	Chenoa	Independent Living Housing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number _____

Fax Number _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Meadows Mennonite Home

0011544 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1999		8	
	2000		9	
	2001		10	
	2002		11	
	2003		12	
FOR OHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Meadows Mennonite Home	COUNTY	McLean
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FACILITY IDPH LICENSE NUMBER 0011544

CONTACT PERSON REGARDING THIS REPORT Roger W. Hasler

TELEPHONE (309) 747-2702 FAX #: (309) 747-2944

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

76,955

B. General Construction Type:

Exterior

Masonry

Frame

Brick, Steel, Wood

Number of Stories

Two

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Meadows Mennonite Retirement Home Independent Living Housing

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	683,400	1920	\$ 15,065	1
2	Facility		1950	27,033	2
3	TOTALS	683,400		\$ 42,098	3

Facility Name & ID Number Meadows Mennonite Home

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			Jan-23	Jan-23	\$ 74,144	\$	50	\$	\$	\$ 74,144	4
5	23		Jan-52	Jan-52	86,314	1,259	50		(1,259)	86,314	5
6	25		Jan-66	Jan-66	225,617	4,483	50	4,512	29	175,963	6
7	94		Jan-78	Jan-78	2,348,846	58,988	40	58,721	(267)	1,585,269	7
8	17		Nov-97	Nov-97	3,898,885	97,472	40	97,472		698,327	8
	Improvement Type**										
9	Various Building Improvements			Jul-79	78,921		20			78,921	9
10	Various Building Improvements			Jan-80	3,362	66	20		(66)	3,362	10
11	Various Building Improvements			Jul-81	3,427		20			3,427	11
12	Various Building Improvements			Jun-83	186,656	9,333	20		(9,333)	186,656	12
13	Various Building Improvements			Jul-84	1,298	49	20	32	(17)	1,298	13
14	Various Building Improvements			Oct-85	31,287		10			31,287	14
15	Various Building Improvements			Jul-86	35,542		10			35,542	15
16	Various Building Improvements			Jul-87	3,888	150	30	130	(20)	2,272	16
17	Various Building Improvements			Jul-88	182,020	8,444	20	9,101	657	150,163	17
18	Various Building Improvements			Jul-89	107,129	4,030	20	5,356	1,326	83,023	18
19	Various Building Improvements			Jul-90	36,676	2,720	10		(2,720)	36,676	19
20	Various Building Improvements			Jul-91	12,480	1,257	10		(1,257)	12,480	20
21	Various Building Improvements			Jul-92	36,879	1,493	10		(1,493)	36,879	21
22	Various Building Improvements			Jul-93	3,505	501	10		(501)	3,505	22
23	Various Building Improvements			Jul-94	93,480	6,686	15	6,232	(454)	65,442	23
24	Various Building Improvements			Oct-95	45,902	2,257	20	2,295	38	21,039	24
25	Various Building Improvements			Jul-96	244,463	9,881	20	12,223	2,342	103,912	25
26	717 Engineering Cad & Survey			Aug-96	675	45	15	45		376	26
27	718 Excavating			Sep-96	2,000	133	15	133		1,099	27
28	732 Boiler Repair - Cleveland			Mar-96	503		3			503	28
29	790 Roof A/C Repair			Nov-96	718		7			718	29
30	810 Window Coverings			May-96	1,039		7			1,039	30
31	794 Sewage Pump Repairs			Nov-96	1,685		7			1,685	31
32	Siding			Nov-97	22		7	3	3	22	32
33	Siding			Nov-97	245		7	29	29	245	33
34	917 Alzheimer Unit			Nov-97	144,484	3,612	40	3,612		25,878	34
35	818 Insulated Glass Rm 42			Sep-97	677	68	10	68		495	35
36	828 Service-Intercom System Repairs			Mar-97	871	21	7	26	5	871	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	833 Fiber Optics - Computer Wiring	Jun-97	\$ 2,887	\$	5	\$	\$	\$ 2,887		37
38	835 Liquid Storage Cabinet Tank	Jun-97	572		5			572		38
39	836 Paging System - Bennett	Jun-97	2,288	136	7	146	10	2,288		39
40	838 Install Heating - Cooling	Jun-97	15,161	1,011	15	1,011		7,587		40
41	839 Compressors (5)	Jul-97	1,653	118	7	128	10	1,653		41
42	843 Window blinds	Aug-97	1,539	128	7	132	4	1,539		42
43	923 Motor a/C Motor & Starter for 2 Ton Unit	Aug-97	715		5			715		43
44	848 Repair Cool	Sep-97	749		5			749		44
45	849 2 Roof top Units	Oct-97	1,295	139	7	151	12	1,295		45
46	850 A/C Part Repairs	Oct-97	733		5			733		46
47	908 Power Server -Timeclock	Nov-97	150	10	15	10		71		47
48	910 - 2 Carrier Heating & Cooling	Dec-97	19,250	1,283	15	1,283		9,083		48
49	760 Intercom Wiring Repairs	Nov-97	696		3			696		49
50	780 Carousel Tub	Nov-97	12,423	828	15	828		5,932		50
51	796 Landscaping	Nov-97	30,518	2,035	15	2,035		14,579		51
52	800 Curtains, Valances	Nov-97	10,077	672	15	672		4,814		52
53	802 Patio Garden Landscaping	Nov-97	12,842	856	15	856		6,133		53
54	813 Fence & Gate	Nov-97	10,162	254	40	254		1,820		54
55	814 Telephone Wiring	Nov-97	1,462	97	15	97		695		55
56	816 Draperies - Clark	Nov-97	869	58	15	58		416		56
57	894 / 915 ASI Sign System	Nov-97	2,547	170	15	170		1,218		57
58	936 Rocks for 2 Courtyards	Sep-98	2,070	138	15	138		864		58
59	937 Asphalt Maintenance	Sep-98	5,500	367	15	367		2,324		59
60	951 Window Room # 51	Sep-98	444	44	10	44		278		60
61	966 Magnetic Gate Contact	May-98	228	33	7	33		218		61
62	967 Carpet Res. Room	Sep-98	330		5			330		62
63	968 Carpet 3 Rooms	Dec-98	793		5			793		63
64	983 Maintenance Shop	Dec-98	909	45	20	45		272		64
65	938 2 A/C Compressors	Jun-98	1,006	144	7	144		947		65
66	954 Heat & Air Thermostat	Mar-98	1,410	201	7	201		1,367		66
67	959 Natural Gas Steamer	Oct-98	7,495	1,071	7	1,071		6,652		67
68	970 Heat Duct Repair	Jan-98	761	108	7	109	1	757		68
69	973 Repair Engine & Generator	Nov-98	1,322		5			1,322		69
70	TOTAL (lines 4 thru 69)		\$ 8,044,496	\$ 222,894		\$ 209,973	\$ (12,921)	\$ 3,590,431		70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,044,496	\$ 222,894		\$ 209,973	\$ (12,921)	\$ 3,590,431	1
2	976 Alarm system Phase 1	Dec-98	44,529	2,226	20	2,226		13,515	2
3	969 Sewage Pump Rehab	Feb-98	7,208	1,030	7	1,030		7,046	3
4	962 Water Tower Rehab	May-98	63,699	3,185	20	3,185		21,117	4
5	955 OSHA Upgrades	Oct-98	111		5			111	5
6	956 Required OSHA Items	Sep-98	458		5			458	6
7	957 Eye Wash Station	Sep-98	585		5			585	7
8	981 - 1 CS Spill Kits	Dec-98	122		5	1	1	122	8
9	988 Repair Roadway	Apr-99	3,500	233	15	233		1,338	9
10	989 Landscaping Improvements	Jun-99	2,259	151	15	151		831	10
11	995 Station 1 Door Keypads	May-99	1,442	144	10	144		805	11
12	996 Station 1 Code Alert System	May-99	15,298	1,530	10	1,530		8,547	12
13	997 Station 1 Nurse Call System	Jun-99	11,924	1,192	10	1,192		6,561	13
14	998 Ceiling Installation	Sep-99	1,945	130	15	130		683	14
15	999 Improvements to Brown Shed	Nov-99	1,288	129	10	129		656	15
16	1004 Safety Bars in Alzheimer's Unit	Feb-99	2,350	157	15	157		916	16
17	1008 Bronze Door & Closer	Mar-99	1,806	120	15	120		691	17
18	1022 Hardware for Exisisting Doors in Alzheimer's Unit	Mar-99	5,536	369	15	369		2,123	18
19	1001 Sensor Base for Alarm	Jan-99	231	33	7	33		195	19
20	1009 Repair Boiler Station 4	Mar-99	1,140	38	5	56	18	1,140	20
21	1049 Repair Generator	Nov-99	3,067	511	5	563	52	3,067	21
22	1050 Water Heater for Kitchen	Nov-99	878	59	15	59		300	22
23	1053 Panic Devices on Doors in alzheimer Unit	Nov-99	688	98	7	98		498	23
24	1027 Alarm System	Apr-99	7,562	378	20	378		2,144	24
25	1028 Storage Cabinets & Installation	Apr-99	5,242	749	7	749		4,248	25
26	1030 Elevator Eye	Apr-99	1,978	132	15	132		749	26
27	1035 Fire Alarm System Materials & Labor	May-99	27,650	1,383	20	1,383		7,726	27
28	1037 Compressor for Freezer	Jun-99	1,809	258	7	258		1,420	28
29	1069 Sewer Improvements (Check Valves)	Sep-99	1,312	66	20	66		347	29
30	1070 New Pipes in Well	Nov-99	921	46	20	46		234	30
31	1071 New Alzheimer Unit Sign	Mar-99	1,144	76	15	76		441	31
32	1048 Station 4 Door Seal Parts & Labor	Nov-99	1,163	78	15	78		397	32
33	1087 Carpet - Station 5	Feb-00	1,126	225	5	225		1,089	33
34	TOTAL (lines 1 thru 33)		\$ 8,264,467	\$ 237,620		\$ 224,770	\$ (12,850)	\$ 3,680,531	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,264,467	\$ 237,620		\$ 224,770	\$ (12,850)	\$ 3,680,531	1
2	1088 Station 5 Remodel	Feb-00	320	32	10	32		155	2
3	1089 Station 5 Tile	Jun-00	530	106	5	106		477	3
4	1090 Bathroom Fixtures - Station 5	Jun-00	1,675	167	10	168	1	756	4
5	1138 Garage Door Enlargement	Nov-00	1,276	128	10	128		526	5
6	1093 Elevator Cylinder	Feb-00	16,746	1,116	15	1,116		5,400	6
7	1092 Fire Alarm System	Feb-00	18,000	1,200	15	1,200		5,806	7
8	1100 Mastercare hydrobath	Mar-00	9,490	1,356	7	1,356		6,445	8
9	1109 Door Locks on Soiled Linen Closet	Mar-00	568	81	7	81		385	9
10	1112 Air Conditioner Motor	Jul-00	657	94	7	94		415	10
11	1114 Air Conditioner Compressor	Aug-00	1,732	247	7	247		1,071	11
12	1132 Alarm System	Jul-00	35,000	3,500	10	3,500		15,467	12
13	1133 Alarm System	Oct-00	18,060	1,806	10	1,806		7,526	13
14	1148 Alarm System Sensor	Dec-00	864	123	7	123		500	14
15	1075 Premium Lawn	Apr-00	755	50	15	50		234	15
16	1076 Parking Lot Addition	May-00	7,355	490	15	490		2,276	16
17	1126 New Controller for Sewer	Jan-00	1,573	225	7	225		1,106	17
18	1127 Sewer Improvements (Check Valves)	May-00	752	107	7	107		491	18
19	1128 Water main Work	Jun-00	2,203	110	20	110		496	19
20	1129 Water Main Extension	Jun-00	8,465	423	20	423		1,905	20
21	1130 Chlorinator	Jul-00	1,389	198	7	198		875	21
22	1170 Generator Repair	Feb-01	506	72	7	72		278	22
23	1173 Generator Repair/Trans.	Mar-01	1,434	205	7	205		779	23
24	1174 Boiler Repair	Mar-01	1,044	149	7	149		563	24
25	1179 Air Conditioner Compressor	Jun-01	700	100	7	100		355	25
26	1182 Air Conditioner Compressor	Jul-01	1,200	172	7	171	(1)	591	26
27	1186 Storm Windows	Aug-01	2,071	207	10	207		690	27
28	1192 Simplex Fire Alarm	Oct-01	763	153	5	153		488	28
29	1249 Phase II Bldg Renov	Mar-02	950,000	31,667	30	31,667		87,192	29
30	1250 Phase II Bldg Renov -K	Apr-02	1,187,500	39,583	30	39,583		107,145	30
31	1280 Renovation 2002	Nov-02	80,684	2,689	30	2,689		5,717	31
32	1281 Renovation 2002	Dec-02	182,708	6,090	30	6,090		12,447	32
33	1295 Pairie Control- 4FCU flow problem	Nov-02	6,694	446	15	446		942	33
34	TOTAL (lines 1 thru 33)		\$ 10,807,181	\$ 330,712		\$ 317,862	\$ (12,850)	\$ 3,950,030	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,807,181	\$ 330,712		\$ 317,862	\$ (12,850)	\$ 3,950,030	1
2	1296 Phase II Renovation	Oct-02	456,101	15,203	30	15,203		32,947	2
3	1292 Garage Doors	Nov-02	1,166	117	10	117		244	3
4	1298 Roof	Oct-02	125,025	4,168	30	4,168		9,215	4
5	1252 Stained Glass -Chapel	Apr-02	1,063	152	7	152		418	5
6	1254 Water Heater	Jun-02	4,599	657	7	657		1,694	6
7	1255 Generator	Jun-02	1,565	224	7	224		567	7
8	1256 Air Conditioner	Jun-02	5,150	736	7	736		1,843	8
9	1257 Air Conditioner	Jun-02	1,495	214	7	214		536	9
10	1211 Heating UN/Steam	Jan-02	1,424	203	7	203		592	10
11	1226 Air Hood	Apr-02	4,970	710	7	710		1,922	11
12	1227 Fire Protection System	Apr-02	2,572	367	7	367		994	12
13	1238 Nation Custom Vent Ducts	Apr-02	830	119	7	119		322	13
14	1289 New Road	Nov-02	3,911	261	15	261		552	14
15	1253 Sub Pump	Apr-02	2,448	350	7	350		947	15
16	1274 Sewage Pump Station	Aug-02	1,906	95	20	95		225	16
17	1275 Lift Station Eng	Sep-02	1,860	93	20	93		212	17
18	1276 Lift Station Eng	Oct-02	1,674	84	20	84		185	18
19	1277 Pump Station Eng	Nov-02	1,169	58	20	58		123	19
20	1278 Lift Station Eng Review	Dec-02	720	36	20	36		73	20
21	1301 Lift Station Eng	Jul-02	950	48	20	48		116	21
22	1302 Pump Station Eng	Aug-02	1,603	80	20	80		189	22
23	1271 Chiller Compressor Replacement	Oct-02	2,418	345	7	345		748	23
24	1310 Medline-Borders & Shades/ Dining Rm	Feb-03	3,195	456	7	456		866	24
25	1311 Phase II Renov Project	Apr-03	244,941	8,165	30	8,165		14,294	25
26	1312 Tile Specialists-Adm Bld Entry	Jul-03	1,455	182	8	182		270	26
27	1313 Tile Specialists-Adm Bldg Hallway	Apr-03	9,350	1,169	8	1,169		1,998	27
28	1314 Tile Specialists - Lounge Carpet	Apr-03	2,950	369	8	369		631	28
29	1327 Code Alert-Security System	Oct-03	69,151	6,915	10	6,915		8,374	29
30	1328 Jay's Plumbing - Hot Water Heater mixing valve	Dec-03	2,980	298	10	298		319	30
31	1330 New Lift Station	Apr-03	97,919	4,896	20	4,896		8,182	31
32	1335 & 1336 Roof Repairs	Apr-04	1,270	95	10	95		95	32
33	1337 electrical	Dec-04	2,900		7	3	3	3	33
34	TOTAL (lines 1 thru 33)		\$ 11,867,911	\$ 377,577		\$ 364,730	\$ (12,847)	\$ 4,039,726	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,867,911	\$ 377,577		\$ 364,730	\$ (12,847)	\$ 4,039,726	1
2	1343+1344 Water Heaters	Apr-04	12,523	887	10	916	29	916	2
3	1347 Water Softner	Oct-04	7,398	123	10	124	1	124	3
4	1334 Asphalt Sealcoat	Sep-04	22,833	2,537	3	2,523	(14)	2,523	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,910,665	\$ 381,124		\$ 368,293	\$ (12,831)	\$ 4,043,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 534,441	\$ 73,438	\$ 73,438	\$	various	\$ 364,940	71
72	Current Year Purchases	37,439	3,133	3,133		various	3,133	72
73	Fully Depreciated Assets	264,561				various	264,561	73
74								74
75	TOTALS	\$ 836,441	\$ 76,571	\$ 76,571	\$		\$ 632,634	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Grounds Maintenance	1999 Dodge D350	Feb-99	\$ 29,024	\$ 484	\$ 484	\$	5	\$ 29,024	76
77	Patient Transport	2004 Pontiac Montana	Oct-04	10,609	530	448	(82)	5	448	77
78	Grounds Maintenance	2004 JD 1420 Mower	Nov-04	7,608	127	154	27	5	154	78
79	Grounds Maintenance	Other	Various	23,620	2,541	2,541		5	17,913	79
80	TOTALS			\$ 70,861	\$ 3,682	\$ 3,627	\$ (55)		\$ 47,539	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,860,065 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 461,377 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 448,491 83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,886) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,723,462 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Residential Housing Units	\$ 1,369,303	\$ 34,110	\$ 849,886	86
87	Residential Vehicles	80,008	9,977	76,884	87
88	CEO House Remodeling	64,925	2,240	29,284	88
89	Land	158,040			89
90					90
91	TOTALS	\$ 1,672,276	\$ 46,327	\$ 956,054	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$
13. /2006 \$
14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input checked="" type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies		117		117	
3	Classroom Wages (a)		687		687	
4	Clinical Wages (b)		343		343	
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments		350		350	
8	Nurse Aide Competency Tests		50		50	
9	TOTALS	\$	\$ 1,547	\$	\$ 1,547	
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,547				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2								13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 161,113	\$	1
2	Cash-Patient Deposits	15,621		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (20,354))	946,155		3
4	Supply Inventory (priced at FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	55,491		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,158,026	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,220,445		12
13	Land	200,138		13
14	Buildings, at Historical Cost	8,395,876		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,113,585		16
17	Accumulated Depreciation (book methods)	(5,696,578)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Process			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,233,466	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,391,492	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (97,542)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(15,621)		28
29	Short-Term Notes Payable	(394,617)		29
30	Accrued Salaries Payable	(76,909)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(43,700)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Accrued Expenses	(228,335)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (856,724)	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	(619,075)		39
40	Mortgage Payable	(5,412,110)		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (6,031,185)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (6,887,909)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,503,583)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (11,391,492)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,300,553	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(135,408)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,165,145	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	338,437	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 338,438	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,503,583	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meadows Mennonite Home

0011544

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,715,823	1
2	Discounts and Allowances for all Levels	(1,034,289)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,681,534	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,337	6
7	Oxygen	7,804	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,141	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,419	13
14	Non-Patient Meals	1,217	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,677	19
20	Radiology and X-Ray		20
21	Other Medical Services	91,268	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 102,581	23
	D. Non-Operating Revenue		
24	Contributions	794,370	24
25	Interest and Other Investment Income***	14,614	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 808,984	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	239,149	28
28a	Other Income	3,407	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 242,556	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,862,796	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,371,424	31
32	Health Care	2,149,161	32
33	General Administration	1,040,108	33
	B. Capital Expense		
34	Ownership	841,947	34
	C. Ancillary Expense		
35	Special Cost Centers	50,349	35
36	Provider Participation Fee	71,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,524,359	40
41	Income before Income Taxes (line 30 minus line 40)**	338,437	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 338,437	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,095	2,345	\$ 80,991	\$ 34.54	1
2	Assistant Director of Nursing	2,027	2,266	53,521	23.62	2
3	Registered Nurses	10,592	11,290	246,672	21.85	3
4	Licensed Practical Nurses	15,136	16,398	293,750	17.91	4
5	Nurse Aides & Orderlies	89,297	97,020	1,085,750	11.19	5
6	Nurse Aide Trainees	136	136	1,030	7.57	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,518	2,899	27,582	9.51	8
9	Activity Director	1,743	2,133	23,540	11.04	9
10	Activity Assistants	6,441	6,909	50,695	7.34	10
11	Social Service Workers	3,172	3,586	57,294	15.98	11
12	Dietician					12
13	Food Service Supervisor	1,972	2,096	30,527	14.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,481	29,629	228,147	7.70	15
16	Dishwashers					16
17	Maintenance Workers	4,273	4,535	66,535	14.67	17
18	Housekeepers	18,759	21,268	192,530	9.05	18
19	Laundry	5,616	6,432	52,830	8.21	19
20	Administrator	1,960	2,366	73,724	31.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,828	6,464	79,778	12.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerk</u>	2,037	2,317	30,652	13.23	33
34	TOTAL (lines 1 - 33)	201,083	220,089	\$ 2,675,548 *	\$ 12.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	429	\$ 19,409	1.3	35
36	Medical Director	28	4,950	9.3	36
37	Medical Records Consultant	23	1,370	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	7	600	10.3	39
40	Physical Therapy Consultant	72	3,853	10a.3	40
41	Occupational Therapy Consultant	29	1,332	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	764	11.3	44
45	Social Service Consultant			12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	603	\$ 32,278		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	454	\$ 9,067	10.3	50
51	Licensed Practical Nurses	1,181	31,230	10.3	51
52	Nurse Aides	2,636	63,953	10.3	52
53	TOTAL (lines 50 - 52)	4,271	\$ 104,250		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
			\$	Workers' Compensation Insurance	\$ 80,517	IDPH License Fee	\$
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	5,575
Robert O. Bertsche	Administrator/CEO	-0-	73,724	FICA Taxes	199,145	Health Care Worker Background Check	462
				Employee Health Insurance	174,297	(Indicate # of checks performed 43)	
				Employee Meals		Life Services Network of IL	6,170
				Illinois Municipal Retirement Fund (IMRF)*		Mennonite Health Services	1,646
				403b Retirement Plan	32,200	Naeir	1,213
				Sick Pay	18,163	Dues & Licenses	1,067
TOTAL (agree to Schedule V, line 17, col. 1)				Life Insurance	9,024	Subscriptions & Newspapers	258
(List each licensed administrator separately.)			\$ 73,724	Section 125 Admin Fee	3,625	NPDES	500
B. Administrative - Other				Employee Appreciation	8,438	Less: Public Relations Expense	(
				Non-Care Benefits	(12,066)	Non-allowable advertising	(
Description			Amount	Employee Vaccines	722	Yellow page advertising	(
			\$				
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 514,065	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,891
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	Description	Line #	Amount	
(Attach a copy of any management service agreement)						\$	
C. Professional Services							
Vendor/Payee	Type		Amount				
Heinold-Banwart, Ltd	Accounting		\$ 13,000				
Advanced Answers on Demand	Computer		9,113				
Wellspring Innovative Solutions	Consulting		3,015				
Hartweg,Turner,Wood, Simki	Legal		539				
Reclassifications							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 25,667				
							</

* Attach copy of IMRF notifications

**See instructions.

[illegible]

Facility Name & ID Number Meadows Mennonite Home

STATE OF ILLINOIS

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XX. GENERAL INFORMATION:

0011544

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 6,170
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8.54
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,053 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 71,370
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
Hskpng & Laundry split on time incurred.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,217
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Heinhold-Banwart, Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.